

Washington's Behavioral Health Workforce Assessment Stakeholder Meeting Summary, July 26, 2016

On July 26, 2016, the Workforce Board, in partnership with Agnes Balassa Solutions LLC, and the University of Washington Center for Health Workforce Studies, convened a meeting to obtain stakeholder input on an analysis of the behavioral health workforce, a project funded through Governor Inslee's Workforce Innovation and Opportunity Act (WIOA) discretionary funds. Approximately 70 people attended in person or by phone. Following are the notes from that meeting.

Introduction:

Meeting participants introduced themselves and responded briefly to the question:

"What is the one thing you would change to address behavioral health (BH) workforce issues in the state?"

Workforce/Pipeline

- More qualified and COMPETENT staff needed.
- Have a cadre of qualified employees/staff, especially in rural areas
- More clinical staff at all levels – an urban problem similar to the rural issue.
- More qualified applicants – the payment rates have a lot to do with it. Our rates are lower than hospitals and they have the same issues with recruiting
- Recognize that the mental health capacity crisis is a workforce issue as well as a bed issue.
- Fix the pipeline.
- Fix shortage of licensed mental health counselors, therapists, clinical social workers in rural areas
- Get more underrepresented students into behavioral health programs (1st generation, low income, people of color, low education...).
- Attract multilingual, multicultural workers that look like the youth we serve (in education settings).
- Connect secondary students to understand what skill sets they need to go into postsecondary training/education
- Sufficient staff to do school-based services. High suicide attempt rate in schools – need more staff to address this – 1 in 5 students have attempted suicide by 8th grade in some schools in the region.
- More recruitment and retention. Too much churn and turnover. You reach your goal and then you're 10 steps back because of transfers.
- More licensed practitioners, particularly for designated mental health professionals
- Advanced Registered Nurse Practitioners practicing throughout the state
- Employing Psychiatric Nurse Practitioners at state mental health hospitals to the full extent of their education and training
- Increased support for prescribing psychiatrist and advance prescribing providers, especially in the early stages of their careers – how do we get to that point while practicing?
- Place CDPs in secondary schools in King and Pierce counties.

Recruitment/Retention

- Ability to recruit new staff and well-trained staff in rural areas.
- More workforce development and retention
- Recruitment, retention, better leveraging of resources
- Fix gaps in recruitment and retention.
- Increase salaries so we can pay staff what they're worth
- Need more \$\$ to attract and retain staff, reduce turnover
- Retention. We're not building out a system unless we get more resources for retention.



- Incentive programs – make sure they're known about, and need a better understanding of what professions should be incentivized by programs such as loan repayment
- Incentives attracting and retaining behavioral health workers to rural areas
- More options for loan repayment
- Better state loan repayment for non-prescribing BH personnel.
- Create training programs for retention.
- Need funders to support adequate salaries. We are hard pressed to recruit folks to provide office hours (in education settings)
- Ensure grads get adequate compensation for behavioral health occupations
- Utilize underrepresented students and the recovering populations – which used to be a major part of the workforce and now they're not because of so many barriers.
- Positive work environment (not just wages) for recruitment and retention (especially in rural areas).
- Reduce staff silos - staff move among facilities too frequently.
- Globally, any ability to pay a little more in salary for MHPs and CDPs will result in longer retention. If we don't get retention to improve in aggregate by about a 18mos or more, we won't have a good platform for integration. We will have to high of a percentage of rookies trying to interact with primary care before they confident, capable, etc.

Increased Integration

Behavioral Health with Primary Care

- Workforce development for integration in primary care
 - efforts to focus on specialty mental health, such as community mental health centers, is futile because we know only 7-10% of the population go to community mental health centers, which is in stark contrast to the 80% that go to primary care. Furthermore, of the people who have mental health disorders, 20% receive care in specialty mental health systems, 21% receive care in primary care and 59% receive NO CARE (but, as the last stat pointed out, these patients still show up in primary care)
- Develop broader curriculum synergy for better integration of behavioral health and primary care.
- Training around integration
- Train behavioral health providers (and mental health providers) to work on integrated teams – actually working with physicians, mid-level providers – lot of push for integrated care, but not a lot of training
- New graduates trained in team based approaches.
- Provide the cross-education needed for integration
- Work more closely with behavioral health providers to ensure the skills and knowledge to serve at an integrated system.
- Building out the pipeline and career pathways for team-based integrated care
- More opportunities to add on additional certs and training.
- Address shortages in outpatient and inpatient care – maldistribution of providers in rural areas and where to head in terms of integration in the state.
- Increased hiring opportunities for occupational therapists in community mental health. We've lost ground in placing students in clinical field sites for training
- More opportunities for PAs to fill some of these roles to offer the possibility of greater integration.



Mental Health with Substance Use Disorder/Chemical Dependency Treatment

- Better recruitment and licensing to support integration within behavioral health, (chemical dependency professionals as well as licensed marriage and family counselors and licensed independent clinical social workers)
- Having licensed mental health staff obtaining their CDP in a reasonable time - they can do this anywhere **EXCEPT** in WA.

Regulations/Credentialing/Reimbursement/Systemic issues

- Reform regulations so we can spend more time with patients, and less doing audits/addressing regulations
- Increase access to behavioral health services for Medicare patients
- Need Medicare to accept billing from licensed mental health counselors, licensed clinical social workers – especially in rural areas
- Get Medicare to pay for licensed clinical mental health professionals
- Fair and equitable reimbursement for behavioral health services. Medicaid rates need to be revamped.
- Medicaid reimbursement rates – we've spent a lot of time training and bringing up staff, and then they find better opportunities in the private sector. Need higher public rates to compete and we need highly qualified staff for this population in particular.
- Increase Medicaid rates so behavioral health providers can be recruited and retained
- Health homes care coordination – have the rates adjusted so every time we have a care coordinator we're not upside down – need \$20K just to onboard them just so they can take their first client.
- Care coordination aspect of health homes needs to be more accessible to children in general. Cannot rely on 15 months of claims data [required for some reimbursement], which you don't have as an infant
- Transition veterans into behavioral health services. Lots of disconnects and certifications don't cross-walk.
- CDP qualification – difficult to get them qualified. In OR they have 3 levels of expertise for CDP professionals. WA's standards are too hard to attain and affects recruitment.
- A faster track CDP license certification for mental health counselors (in education settings).
- Address pay disparities at community mental health clinics – and address caseloads
- Fix overburdened clinical training environment – difficult to find clinical training opportunities but sites are overtaxed. Fix the lack of reimbursement for preceptors to spend time with students. Need more seamless authorization
- Rescind allowance for clinicians to open private practice with new associate's license. They are inexperienced, lack supervision, team support and are not connected to agencies. Recommend that all clinical hours toward full licensure be required in an organizational setting (side effect of increasing workforce)

Incentives/Innovations

- Additional incentives for college interns and universities to develop a good partnership and network to see more fellowships, paid internships, paid supervision and retention of mental health professionals
- Leverage telemedicine, AIMS model of collaborative care, and other creative solutions -
- we never have enough psychiatrists to meet our needs.
- Training in evidence based practices. Not sure programs have kept up with the pace of behavioral health services
- More tele-psychiatry and telehealth.



- Means to recruit more students and offer more incentives to encourage people to enter the field and work in areas with greater need – grants, scholarships, loan repayment to encourage people to enter the field and work in the area of greatest need.
- Make becoming a CDP less expensive. Need incentives to reimburse CDPs for their time – and if they're in recovery themselves, they need resources to help with the ongoing expenses such as lab tests, etc. Too many barriers for CDPs.
- Bring residents into rural areas so they see the type of work they would do in a practice.
- According to the WA Workforce Shortage Survey Results in 2014, caseload size, support, supervision, training and work environment were almost just as if not more important than money.

I have interviewed hundreds of clinicians over the years and MOST will take \$2 or \$3 less per hour to work in an environment that is supportive and in a clinician supporting culture RATHER than a metric and number driven culture.

- Beyond initial training, ongoing consultation and coaching is critical
- Vicarious trauma and compassion fatigue are organizational-level issues and acknowledgement must be ingrained in the culture
- You know, another thing to think about in the whole equation is public service loan forgiveness. behavioral health clinicians that stay in the nonprofit or public sector should qualify to have their loan balances forgiven after 10 years of work (should that program work as advertised when the first group of people complete 10 years in 2017)

Data

- Improve reporting and data collection
- Reliable data sources by which we can measure population need

Other

- Access – need more adequate access.
- A systematic plan on how to address the shortages – not just document them
- Obtaining qualified, timely access for rural populations. Looking for a systematic, intentional approach

Occupation and Skill Shortages

In small groups facilitated by project staff, meeting participants addressed the following:

What kinds of behavioral health workforce needs do we have in the state?

- *Participants were asked to comment on shortages (prolonged vacancies) of BH occupations and other health occupations to support integration, skills lacking (new employees, incumbent workforce), and what additional training is needed (new employees, incumbent workforce).*

Responses

I. Occupations with shortages (prolonged vacancies):

- We have shortages of all behavioral health occupations because reimbursement/resources are too limited
- Especially shortages of rural providers
- Urban and suburban settings face their own shortages and unique barriers – cost of living is higher, patient loads (and often acuity) are higher, work sites are not eligible for loan repayment programs, etc.



In addition – specific occupations mentioned were:

- Adv. Psychs (Children's, Esp. Aging Population); Mental Health Professionals (MHP) can specialize in particular population groups, Geriatric, Developmental Disabilities, Children, Ethnicities, etc. The requirement is 100 hours (?) of supervision by a MHP specialist to qualify.
- Board Certified Behavioral Analysts (For Autistic Populations)
- Certified Medical Assistants (Transition)
- Chemical Dependency Professionals (CDPs)
- Chemical Dependency Providers - Certified
- CDP's to work with addicted people
- Clinical Supervisors
- Practitioners treating co-occurring MH/CDP clients (Rural) - The reimbursement rates are bifurcated, you can only bill under Substance Use Disorder funding or MH funding, it remains in silos. And the WAC hasn't been written so programs can't be implemented.
- Designated Mental Health Professionals (Chemical dependency/Substance abuse treatments)-this dual role is called Designated Crisis Responders, they have the authority to ITA someone with a mental illness or substance use disorder to a locked facility for 72 hours. The problem currently is there are no secure detox facilities for the SUD ITA law to be enacted, RCW 70.96B
- Designated mental health providers (DMHP) (Crisis Side) (Rural)
- Early Intervention Workforce (e.g., for schools) Mental Health Counselors, such as CDPs, ESA Educational Schools Associate
- Entry Level providers (need providers trained at the Bachelors Level as well as those with higher level degrees)
- Inpatient Psychologists
- Licensed Counselors (Migrant Health)
- Licensed Mental Health Professionals
- Licensed Mental Health Therapists (Rural)
- Licensed Social Workers
- MA Social Work (Migrant)
- Marriage & Family Therapists (Migrant)
- Masters level providers
- Masters Social Workers/Licensed Social Workers
- Mental Health Professionals
- Prescribers
- Non-prescribers, esp. rural areas
- Occupational therapists
- Occupational therapy assistants
- Peer counselors/Health navigators
- Peer support staff
- PhD Psychologists
- Physician Assistants in General
- Psych & Nurse Psych (in Community Settings)
- Psych (BH) In the public behavioral health system, psychiatrists are in much more demand than psychologists
- Psych Home Health Service Nurses
- Psych Medication Providers (psychiatrists, psych NPs)
- Psychiatric ARNP's & PAs
- Psych Nurses (6 month & opening)
- Psychiatric Nurse Practitioners (BH)
- Psychiatrists - retirement is threatening the supply
- Registered nurses (all)
- Registered Nurses (King)
- Supervisors (Clinical)
- Therapists 1.2.3's; especially licensed
- No therapy in Community Migrant Health (Nurses)

II. Skills that are lacking/in short supply

Patient/client care

- Prevention
- Skills related to patient complexity



- Not always “Client on the Couch” model
- Real world skills (In cultures, environment, community acceptance, online, immediate, culture shift)
- Children’s staff (Rural)
- Community re-integration specialists
- Too little screening, and lack of empowerment of providers.
- Treating late stage patients is de-moralizing for the provider
- Prescribing suboxone
- Cultural competence
- Specialty skills medically assisted treatment (MAT - evidence-based practice skills)
- Bilingual staff
- Culturally appropriate training (Tribe)
- Minority bilingual (to meet cultural diversity needs)
- Age appropriate care
- BH to know primary care & vice versa – Common Language
- Understanding the culture of primary care
- Supervisory skills (Clinical skills)
- Clinical sites-clinical skills
- Forensics
- Acuity: Least experienced BH workers end up treating most difficult patients
- Telehealth access & training
- ARNPs & PAs who can prescribe suboxone

Patient documentation/Reimbursement

- Medicaid document requirements
- Paperwork and documentation skills
- Information system professionals specialized to BH (Rural)
- Care coordinating (Need for training standard of language)

Credentialing

- Use of foreign-trained providers (licensing, reciprocity, skills transfer)

Other

- Broadening definition of BH (start early w/BH Management)
- Accurate differential diagnosis (reimbursement issue – time)
- How to access relevant healthcare info.
- Important context for WHY skills are lacking is the turnover/failure to recruit and retain, which leads to experienced professionals moving out of the field or at least out of the positions/settings where they are most needed/patients are most acute.
- There is a disincentive to invest in training/career ladders when there is no expectation that your workforce will remain stable

III. Training needed

Patient/client care

- Redesign the system (of providers)
- Social determinants of health
- Training for co-occurring conditions (mental health & chemical dependency)
- How to reduce burden of work



- Community mental health training (jobs available)
- Affordable training in evidence based practices via distance learning/distance education
- Provide services in a non-clinic atmosphere
- Integrate CDP Skills

Patient documentation/Reimbursement

- Mismatch in training
- Supervision (Florida=billable service)

Education Pathways

- BH pipeline from community colleges to Masters programs
- Psych residencies (in state/rural)
- Experience required for inpatient psych?
- Mismatch in postsecondary training
- Training in consultation
- Initiate recruitment into BH professions in pre-college

Barriers

In small groups meeting participants were asked to address the question:

What are the workforce barriers that affect access to behavioral health in WA?

- *What are barriers affecting policy, education, training, etc., including barriers to you/your organization in meeting population's BH workforce needs?*

Responses

IV. Barriers

Barriers to integration with primary care

- Stigma attached to behavioral health/lack of understanding of behavioral health's importance
- Different definitions/goals within behavioral health and across behavioral health and primary care
 - e.g. how "recovery" is defined in these practices and applied for various patients
- Primary Care model for diagnosis does not leave enough time to appropriately identify behavioral health issues (this is related to the reimbursement structure)
- The time pressure related to approvals, reimbursements, authorizations
- Licensed mental health staff not able to work in all facilities because of Medicaid (reimbursement regulations)
- A large number of psychiatrists won't see Medicare/Medicaid patients

Barriers related to insufficient workforce training

- Lack of open access to loan repayment for non-prescribing occupations
- Issues with loan repayment programs in general – not enough funds/not for all occupations/worksites and care settings
- Availability of placement sites for clinical training/lack of placement sites that fully represent the diverse, "real world" aspect of delivery of patient care



- Lack of access to preceptors for clinical training, and especially preceptorship for Psych ARNP's
- Lack training for integrated service delivery
- Lack of intern/resident training
- Cost of Training for incumbent workers
 - Reimbursement for time, travel, etc.
 - Incumbent worker training is not funded (this is exacerbated by high turnover)
- Lack of faculty to train occupational therapists
- Aging occupational therapists
- Supervisory skills training log jam
- Lack of a fast track for primary care providers to get behavioral health training
- Access to supervisors for CDP training
- Lack of work-based learning opportunities in graduate medical education
- Community health settings

Barriers to insufficient workforce certification/licensing

- Washington requirements for certification - over-regulation, masters level required to provide many services
- Slow license process (phone time, lack of resources)
- Lack of a fast-track to license veterans
- Inability to license out of state providers
- Granted Licensing Privileges
- Lack of a fast track for primary care providers to get behavioral health certification

Barriers to recruiting/retaining behavioral health workers

- Wages too low compared to training/education costs for many behavioral health occupations
- Work environment (not resourced to adequately support staff)
- Lack of resources to provide equitable pay (compared to other health care settings)
- Issues regarding job quality
- Not a lot of professionals (nurses, etc.) want to work with detoxing patients
- Burn out
- Pay does not correspond to caseload – even with higher pay
- Developing and keeping a diverse workforce – even if you start recruitment early, those with diverse backgrounds are in high demand and we lose them to better areas
- Lack of or too few career pathways within professions
- Community Health
 - Loses providers to private practice due to the paperwork burden, low pay, low satisfaction, high caseload and complexity, late to system
 - Too hard to become a CDP: too expensive, no reciprocity with other states, outdated model, viewed as a separate profession.
- Caseload (“naughty lists”, low satisfaction (Community Mental Health) - productivity models are inappropriate to the acuity of the patient and intensive nature of the work
- Treatment of behavioral health tends to occur at late stages rather than prevention and earlier detection, so cases are harder to address, which can be demoralizing

Barriers related to reimbursement/regulations

- Need for a State Plan Amendment for co-occurring disorders
- The need to increase rates/reform payment, especially for behavioral health transition



- Medicaid rates (US Billable at Harborview)/Medicare rate disparity.
- Regulatory restrictions for Medicaid patients (for co-occurring conditions)/inability to bill for co-occurring disorders even when there is sufficient funding
- Prescribers reimbursement
- CDP [chemical dependency provider] reimbursement rate
- Rural area payment challenges
- The regulatory burden for private practice
- Interpretation of codes (problem with documentation)
- Oregon regulations are more clear
- The single biggest barrier is lack of resources to overcome known, solvable barriers



Data challenges

- Lack of data integration across plans (limits ease of access)
- Total lack of data – cannot create adequate projections for workforce needs

Recommendations

In small groups meeting participants were asked to address the question:

What are your recommendations for addressing behavioral health workforce needs?

- *What are innovations you know of that have helped in other places? Specific approaches to overcome barriers to policy, educating/training, and/or payment/reimbursement? Best “bang for the buck” changes that could happen now? What’s needed down the line?*

[Please offer edits, clarifications and/or comments regarding the recommendations below]

Recommendations for integration with primary care

Recommendation	Comments
1. More telehealth	
2. Consider providing hand-offs between Primary Care & BH at a level below the physician level.	Some FQHC have this model in their clinics, Unity Care NW in Bellingham is one of them
3. Implement mobile BH workforce (look for models)	
4. Behavioral Health Consultation model (psychiatrists are part of primary care visits)	UW has a consultation group working with Primary Care for children's MH care, Catholic Community Services participates in this consultation group
5. Explore a Group Health ARNP model – with a visit post discharge	

Recommendations re: workforce training

Recommendation	Comments
6. Explore apprenticeship models in nursing homes	
7. Expand the BH Assistant apprenticeship at community mental health clinics (for Medical Assistants)	
8. Provide integrated care training/cross training/training on integration/Focus training on integrated care (Primary Care)	
9. Provide training for doctors re: BH issues	
10. Support onsite training (cross-training increases morale)	



11. Identify & scale-up K-12 career pathway programs for underrepresented minority (URM) students into health careers	
12. Offer Youth Mental Health First Aid Training	
13. CDP workforce - professionals with masters degrees or higher, could be trained by their employer in substance use disorder treatment (see new DOH rules and new Washington Administrative Code)	
14. Support education pathways for bachelors level staff and support roles for bachelors level staff	
15. Address paperwork burden by training on how to do it	
16. Create a 2 to 3 week academy for new hires (formalize baseline training)	
17. Explore opportunities for more field-based (real world) training	
18. Use community colleges to provide training (bang for buck)	
19. See online case managers in training – lead to credentialing	
20. Provide crisis care education at the university level Update curriculum to reflect evidence-based practices, managed care, real world	
21. Provide incentives & training for outpatient primary care providers to care for low level BH needs	
22. Look at the Yale Supervision Training Model	
23. Expand residency programs – especially for psychiatrists & rural/underserved	
24. Provide training for school officials on BH issues	Curriculum revisions at all levels of the academic spectrum to encompass behavioral health, Evidence Based Practices, Integration of Care, etc.
25. Make quality continuing clinical education (CE) free and more accessible)	
26. Incentivize community mental health providers to take part in internship programs/and be clinical sites	
27. Expand HEET (Hospital Employee Education and Training) grants to support lower level incumbent workers to navigate education to progress along career pathways while remaining employed.	

Recommendations re: workforce certification/licensing

Recommendation	Comments
28. Provide access to Applied Behavior Analyst Certification (new certification)	



29. Improve pathways for immigrants with BH training to become credentialed	
30. Masters CDP Cert	
31. Include SUD in scope of practice for LCSW & LMHC	
32. Streamline credentialing for payment by 3rd party insurance	
33. Look at reciprocity in licensing as a way to address supervisory back log <ul style="list-style-type: none"> CDPs must be trained under an approved supervisor (All of the experience must be under an approved supervisor as defined by <u>WAC 246-811-049</u>.) So if someone already has a CDP certification/license in another state, can there be reciprocity? 	
34. Identify/implement fast track for veterans to enter BH jobs	

Recommendations for recruiting/retaining behavioral health workers

Recommendation	Comments
35. Identify where retention is working and replicate/focus resources on those models – beyond loan repayment	
36. Identify best practices for retention	
37. Loan Repayment	
38. Expand & increase loan forgiveness for masters level providers, especially in rural areas	
39. Loan repayment – increase the size of the pot, the # and type of occupations covered, definition of professional shortage vs medically under-served (CDPs are currently not included)	
40. Caution re: expansion of loan repayment - could lead to loss of physicians	
41. Scholarships targeted early to draw students into health occupations	
42. Living allowances/stipends for students during their clinical training	
43. Better out-of-state & international reciprocity	
44. Reciprocity with other states for CDP & MSW credentials	
45. Invest in out-of-state recruitment	
46. Improve workforce satisfaction	
00. address caseloads	
00. increase wages and benefits commensurate with public sector similar jobs, or event private sector in acute or primary care	



Recommendations re: reimbursement/regulations

Recommendation	Comments
47. Increase resources	
48. Increase Medicaid Rates	<p>During the 2015 session, the legislature moved Medicaid rates to the bottom of the rate bands, which reduced funding by \$16.46 million GF-S (the total cut was \$32.93 million). Because Medicaid is by far the largest funder of community behavioral health services, Medicaid capitation rates are a primary determinant of community mental health agencies' (CMHAs) ability to recruit and retain a qualified workforce. CMHAs simply cannot hire competitively or retain qualified staff when Medicaid rates are pushed to the bottom of the rate bands. This is because being funded at the bottom of the rate bands forces provider organizations to operate at the bottom of the clinical salary ranges (i.e., providers are forced to pay salaries in the 25th percentile).</p> <p>If rates are not increased, they will continue to affect the workforce shortage as well as all of the things that flow from a lack of outpatient capacity, including overloading the crisis, inpatient, and criminal justice sides of the system.</p>
49. Adopt a 1/10 of 1% of county sales tax for mental health in all counties	
50. State Medicaid program rates need to fully cover cost of care	Including specifically setting out the full care team and caseloads for each member of the care team
51. Increase case rate/overall rate for BH (at the state level w/legislative activity required)	
52. Reimburse for consult time/ Reimburse for psychiatric consultation for primary care providers	
53. Reimburse for Telemedicine for BH <ul style="list-style-type: none"> Pay for provider to provider telemedicine consultation time get Medicaid/Medicare accept telemedicine for reimbursement 	
54. Telepsychiatry (approved mental health professional not possible?)	
55. Move away from productivity payment methods – value over volume	
56. Recode payment for co-occurring conditions	
57. Access county sales tax dollars for mental health, chemical dependency professionals	This can be a problem if the counties do not coordinate their funding priorities with the BHO, can cause duplicative efforts and/or supplanting of funds



58. Remove restrictions for BH occupations to do business with behavioral health agencies only and masters level only.	
--	--

Data recommendations

Recommendation	Comments
59. Streamline burdensome state data reporting requirements - see OR state plan for a better example	
60. State Central Data Repository in process – continue work on this	
61. Centralized Database of Prescription & Services	

Additional promising practices to explore

Recommendation	Comments
62. SBIRT (screening, brief interventions, and referral to treatment) Research Model in Community Clinics	
63. Psych Home Health Nurse (Connecticut Model)	
64. Early intervention for BH issues – can reduce the load and make the workplace more attractive/less demoralizing	
65. Look at alternatives to school suspension for BH issues	
66. Encourage more school counselors to be clinical social workers (CSWs)	
67. Re-start student assistance services through OSPI for CDP & MH	
68. Integrate BH with medical settings, in a co-located model	
69. PAL (partnership access line) system for child psych assistance (partnership supporting child mental health consultation by phone between child and adolescent psychiatrists and primary care providers)	
70. Promote care coordination roles as a bridge between BH providers & medical and community services, and as occupations that don't have to be Master's level	
71. Get occupational therapists at the community health level	
72. Increase access to and training about the value of supported employment, a proven strategy that actively support the employment of those with BH issues as part of their treatment plan (access to benefits, reduced isolation, increased accountability)	



Other

Recommendation	Comments
73. Stop calling it Behavioral Health (barrier! Negative connotation)	
74. Create an education campaign on "what is behavioral health"	
75. Consider PSA's to show the down side of marijuana use especially for youth with BH issues	Not only for marijuana, the state should develop a PR platform that addresses stigma, access to services and recovery

